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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, partnership, corporation, or association that is certified by the Virginia Department of Health and that has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

FREEDOM OF CHOICE

The patient shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid program prior to billing for any services provided to Medicaid recipients. Billing forms will not be issued to providers who do not sign a participation agreement.

All providers must complete the participation agreement and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

Upon receipt of the above information, a seven-digit provider number will be assigned to each approved provider. This number is to be used on all claims and correspondence submitted to Medicaid.

Instructions for billing and specific details concerning the Medicaid program are contained within this manual. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid program.

All providers must sign a Medicaid Provider Agreement (see "Exhibits" at the end of the chapter for a sample Provider Agreement.) The signature must be an original signature. An agreement for a hospital must be signed by the authorized agent of the provider. The

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Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized agent and the fact that a principal agent relationship exists.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider can download a participation agreement from the DMAS website (www.dmas.state.va.us) or can request a participation agreement by writing, calling, or faxing the request to the address listed below:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Division of Licensure and Certification of the Virginia Department of Health does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify First Health Provider Enrollment Unit, in writing, whenever there is a change in any of the information that the provider previously submitted.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

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- Provide services, goods, and supplies to recipients in full compliance with the requirements of § 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party.
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission.
- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or recipients for broken or missed appointments.

Example: If a third party payer reimburses \$5 out of an \$8 charge, and Medicaid's allowance is \$5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements.
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use DMAS-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

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Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this manual on documentation of records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the DMAS. DMAS shall not disclose medical information to the public.

HOSPITAL PARTICIPATION CONDITIONS

General Acute Care Hospitals

A hospital is eligible for participation in the Virginia Medical Assistance Program if it meets one of the following criteria:

- Is certified by the Virginia Department of Health (VDH) as meeting the conditions for participation under Title XVIII of Public Law 89-97
- Is limited to an age group not eligible for Title XVIII benefits, but is accredited by the Joint Commission on Accreditation for Hospitals and has a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review

Rehabilitation Facilities

DMAS covers intensive rehabilitation services in rehabilitation hospitals and in rehabilitation units of acute care hospitals. To become a provider in this category, the facility must:

- Be certified by the VDH as a rehabilitation hospital, or be certified by VDH as a rehabilitation unit in an acute care hospital.

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- Have met the requirements to be excluded from the Medicare Prospective Payment System.
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.

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REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- Workers' Compensation - No Medicaid program payments shall be made for a patient covered by Workers' Compensation.
- Other Health Insurance - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce its lien established under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

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In the case of an accident in which there is a possibility of third-party liability, or if the recipient reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the hospital is requested to forward the DMAS-1000 to:

Third-Party Liability Casualty Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

(See “Exhibits” at the end of this chapter for a sample of this form.)

ASSIGNMENT OF BENEFITS

If a Virginia Medical Assistance Program beneficiary is the holder of an insurance policy which assigns benefits directly to the patient, **the hospital must require that benefits be assigned to the hospital or refuse the request for the itemized bill** that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

[Effective Date: 1-23-92]

All physician or other health care professionals’ documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. (See “Exhibits” at the end of this chapter for a sample of this form.) All documentation must be completely dated with the month, day, and year.

DOCUMENTATION OF RECORDS

The Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

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- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

REVIEW AND EVALUATION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. This function is handled by the Virginia Medical Assistance Program's Prepayment and Postpayment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on hospital utilization review activities and on physician certification of the need for care may be found in Chapter VI, Utilization Review and Control.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or item of value for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

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Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General of Virginia. Provider records are to be made available to personnel in this unit for investigative purposes.

Further information on submission of fraudulent claims may be found in Chapter V of this manual.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FH-PEU thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325(c) of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to § 32.1-313 of the Code of Virginia. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

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MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the FIRST HEALTH - Provider Enrollment Unit at the address given under "Requests for Participation" earlier in this chapter.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

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The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

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**Department of Medical Assistance Services
Medical Assistance Program
Hospital Participation Agreement**

If re-enrolling, enter **Medicaid** Provider Number here→ _____

Check this box if requesting new number→ ☐

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

PHYSICAL ADDRESS

(REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS)

NAME

ATTENTION

ADDR LINE 1

ADDR LINE 2

CITY, STATE, ZIP

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Enter 6-digit **MEDICARE** provider number here→ _____

Check this box if Rehab Hospital→ ☐

1. The provider is currently licensed and certified under applicable laws of this state. (Check the item which applies to your hospital.)

____ A.) As of _____ (Date) has been fully certified for participation with Title XVIII (Medicare) of Public Law 89-97.

____ B.) Is limited to an age group not eligible for Title XVIII benefits, but is as of _____ (Date), accredited by the Joint Commission on Accreditation for Hospitals and has a utilization review plan which meets Title XVIII AND Title XIX standards for utilization review.

2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.
9. This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use only

Director, Division of Program Operations _____ Date _____

For Provider of Services:

Original Signature of Administrator _____

Date _____

Title _____

____ City OR ____ County of _____

IRS Identification Number _____

(Area Code) Telephone Number _____

IRS Name (required) _____

Mail or fax **one** First Health - VMAP-Provider Enrollment Unit
completed **original** PO Box 26803
agreement Richmond, Virginia 23261-6803
to: 1-804-270-7027

Medicare Carrier and Vendor Number (if applicable) _____

VIRGINIA



Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138)

require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____
IS TREATMENT COMPLETED _____ YES _____ NO _____

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87



**MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE**

Please review and check the blocks which pertain to you:

☐ **MAILING SUSPENSION REQUEST:**

I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

☐ **COMPUTER GENERATED CLAIMS:**

I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

(Service Center Preparing Invoices)

Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

Prior service center code: _____

☐ **SIGNATURE WAIVER:**

I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**

I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105